

Framing quality improvement tools and techniques in healthcare: The case of Improvement Leaders' Guides

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Framing quality improvement tools and techniques in healthcare: the case of Improvement Leaders' Guides

Introduction

Healthcare systems have turned to a variety of 'improvement strategies' aimed at promoting, enabling and encouraging change to happen (Walshe, 2003). Quality improvement has been one such effort to achieve better patient outcomes, better system performance and better professional development (Batalden and Davidoff, 2007: 2). Rather than effort alone, it is based on the improvement of systems and processes (Berwick, 1996; Institute of Medicine, 2001) through a variety of tools and techniques. Dale and McQuater (1998) suggest these tools and techniques provide a means and a starting point for analysing problems, identifying and diagnosing gaps in performance and measuring whether implemented change is producing desired improvements. They include flow diagrams to understand processes; run charts and control charts to understand variation and measurement within these processes; and learning cycles (or 'Plan Do Study Act' cycles) to carry out small tests of change that lead to improvements (Batalden and Davidoff, 2007; Langley et al, 1996; Plsek, 1990; Dale and McQuater, 1998).

A variety of formative and summative research has analysed the effects of quality improvement interventions. These include Total Quality Management (Joss and Kogan, 1995), Continuous Quality Improvement (Shortell et al, 1998), Business Process

Reengineering (McNulty and Ferlie, 2002), Clinical Microsystems (Williams et al, 2009) and Lean thinking (Bishop and Waring, 2010). Across these varying initiatives and organizational contexts, what tends to unite this research is that despite ‘pockets of improvement’ showing benefits to patient care and resource utilisation, quality improvement initiatives tend to be limited by their construction as a ‘bolted on’ managerial intervention and by a general lack of interest or compliance from healthcare professional staff.

Based on this ‘patchy’ evidence base, what we have seen more recently are calls for new approaches that study the contextual and contingent features of quality improvement interventions (Bate et al 2008; Berwick, 2008; Walshe, 2007; Greenhalgh et al, 2004; Ovretveit and Gustafson 2002). This call was captured by Batalden et al (2011) who suggested that understanding quality improvement required a change in thinking with greater concentration on the ‘social act’. In contrast with ‘biological wizardry’ and ‘technical fixes’, Batalden et al (2011: 103) suggest improvement lay on ‘mastering the complex realities that drive, and that inhibit, human performance, professional behaviour and social change’. It included a greater understanding of organisations as political systems (Langley and Dennis 2011) and intergroup relationships and dynamics (Bartenuk 2011). Epistemological issues related to improvement also required greater consideration (Perla and Parry 2011). Knowledge for improvement required an acceptance of both ‘homogeneity’ and ‘heterogeneity’ with greater attention to language, categories, methods and rules of inference (Davidoff 2011). At a practical level, it meant developing and appointing leaders capable of using the sciences of improvement.

The purpose of the following paper is to analyse how a collection of quality improvement tools and techniques called the Improvement Leaders’ Guides (ILGs) were interpreted and framed within English healthcare settings. It builds on other research by presenting a critical and theoretical understanding of how quality improvement interventions interact with pre-existing healthcare practices (Waring and Bishop 2010; Joosten et al, 2009; Timmermans and Berg, 2003) and how tools and techniques are characterised by ‘interpretative flexibility’ in the sense that they are imbued with social and cultural meaning (Waring and Bishop 2010). Interpretive flexibility expresses the idea that technological artefacts such as improvement tools and techniques are both constructed and interpreted (Doherty et al 2006). They represent ‘different things to different actors’ (Law & Callon 1992: 24) as various social groupings associate different meanings to them. In doing so, the paper also documents a

significant development in the quality improvement agenda within the UK and beyond – that being the work of the NHS Modernisation Agency (MA). It has relevance to all quality improvement researchers and practitioners by raising important questions about our understanding of quality improvement tools and techniques and distributing leadership across healthcare settings.

Quality improvement in the English NHS

The healthcare system in England has introduced a variety of policy measures aiming to reform its organization and delivery. These overlapping strategies have aimed to ‘modernise’ infrastructure, improve efficiency, quality, and responsiveness to patients’ preferences (Stevens, 2004; Ham, 2009). As part of its policy goal to redesign healthcare around the patient (Department of Health, 2000), the New Labour government (1997-2010) introduced a number of quality improvement interventions to support continuous learning and improvement of health services. These included NHS Collaborative programmes, the NHS Modernisation Agency, the National Patient Safety Agency and the NHS Institute for Innovation and Improvement.

What united these initiatives and institutions was the view that to build capacity and capability in relation to improving healthcare organizations required a greater emphasis on quality improvement methods and principles. The approach formed part of an international preoccupation with healthcare redesign techniques to improve healthcare systems (Locock 2003). Locock (2003) suggests healthcare redesign blended the methods and principles of Continuous Quality Improvement (CQI) and Business Process Reengineering (BPR) in ‘thinking through from scratch the best process to achieve speedy and effective care from a patient perspective’ (Locock 2003: 54; Locock 2001). The approach emphasises the importance of continually reflecting upon, measuring and changing work processes in an effort to improve workflow, reduce waste and add value (Waring and Bishop 2010).

From 2001 until 2005, the NHS Modernisation Agency (MA) was established to train and support healthcare organizations in local service redesign and the spread of best practice. It

provided range of improvement programmes and initiatives that promoted whole systems approaches by ‘rethinking the way that services are organized’ and ‘taking out frustrating waits and delays in the patient journey’. A key feature of these initiatives was the ‘horizontal spread’ of reengineering and service redesign techniques (Stevens, 2004: 39), particularly those advocated by the Institute for Healthcare Improvement in the US. These included the ‘breakthrough’ collaborative method, the PDSA learning cycle and the ‘Model for Improvement’ (Langley et al 1996). Alongside tools and techniques, the MA also promoted the role of leadership within local improvement efforts by encouraging individuals with ‘good ideas, entrepreneurial flair and expertise’ to lead and inspire others (MA, 2002a: 15).

One of the innovations produced by the MA in its attempt to blend systems thinking and leadership development was the production of Improvement Leaders’ Guides (ILGs). ILGs were developed following feedback from NHS Collaborative programmes that more guidance was needed to support the application of tools and techniques at a local level (Millar 2009). They were produced to help teams understand ‘the basic principles’ of improvement and provide existing improvement leaders with support when mapping and planning training and development programmes that used improvement topics, tools and techniques (see Table 1)(MA, 2002b: 1-3). The cumulative effect of this production was a ‘Body of Knowledge’ covering the ‘harder’ side of systems and project management and the ‘softer’ people side of improvement in areas of personal and organizational development (Penny, 2003: 3).

Table 1

What was particularly innovative about this collection of quality improvement tools and techniques was their attempt to overcome the previous shortcomings of quality improvement in healthcare settings. The experience of NHS Collaborative programmes found that tools and techniques such as process mapping and capacity and demand training did provide ‘key levers for change’ as did the emphasis on multi disciplinary working and networking (Robert et al, 2003: 425-427). However, such tools and methods were often aggregated into time limited projects as ‘off the shelf’ programmatic methods rather than creating generative change or networked learning communities (Bate et al, 2002: vii).

Clinicians tended to be less convinced by the value of the Plan-Do-Study-Act (PDSA) cycle approaches or the sustainability of improvements made (Ham, 2003: 2-3; Robert et al, 2003: 433). Where pockets of improvement existed, these tended to rely on 'highly committed and competent' individuals.

Such findings resonate with more recent research studying quality improvement methods in the English Safer Patients Initiative (Health Foundation 2011). This found that staff experience of process measurement was very positive as real time information helped people understand cause and effect and engender local ownership of data for improvement. However, it also found that contexts lacked the appropriate measurement systems to define and implement the improvements made. The dominant paradigm centred on data for performance management rather than measurement for improvement (Health Foundation 2011). Staff engagement also proved to be an issue as medical staff generally did not feel as engaged in the work.

The production of ILGs formed part of an approach to encourage greater spread and sustainability of improvement tools and techniques (see MA 2004; Matrix RHA 2003 a, b). They are underpinned by the view that although the production of 'mass media' can create awareness for improvement, the method for diffusing innovation is more likely to be through interpersonal influence, social networks and horizontal peer influence (Greenhalgh et al, 2004; Gollop et al 2004; Fraser 2002; Jones 2005). To nurture organizational and professional cultures in relation to quality improvement requires a combination of macro framing and micro individualising of quality through team building and learning (Bate et al 2008: 33; Shortell et al 1998).

Also connected to ILGs is a more de-individualised concept of leadership as something that can be 'distributed' between different layers within organisations. The role of local leaders is to enable, facilitate and support these different learning communities and networks by engaging in a collaborative approach with local 'activists' in order to nurture a critical mass of support and facilitate a 'movement mentality'. Leaders do so by paying greater attention to aligning and framing words and language to capture people's attention and invest emotional energy (Bate et al, 2004: 65; Bate and Robert, 2002). If successful, spontaneous collaboration occurs as previous 'followers' take on and enact leadership roles (Currie and Lockett 2011; NHS Institute for Innovation and Improvement 2007; Bate et al 2008).

Empirical evidence about the application of these ideas and theories about improving healthcare is relatively underdeveloped. Some notable evidence does come from Mowles et al (2010) who studied the application of methods to support complexity thinking within the NHS. This found that complexity thinking did not translate easily in contexts characterised by 'a tradition of linear cause and effect'. However, staff using such methods pointed to improved skills and some observable improvements in service provision. A literature review of distributed leadership in public sector by Currie and Lockett (2011) suggested that approaches emphasising teamwork and collaboration resonated with health and social care contexts where change and improvement maybe required. That said, this review also suggested that the complexity of professional and policy institutions may render attempts to enact such distributed leadership difficult as the approach remained largely abstracted from the professional and policy constraints upon leadership influence in public service settings (Currie et al. 2009).

ILGs can be seen as part of a shift from quality improvement built on 'rational planned' change approaches associated with TQM and BPR towards a view of leading change implicitly focused on meaning making as the central medium and target for changing mindsets and consciousness (Marshak and Grant, 2008: 10-11; Van de Ven et al, 1999; Fitzgerald et al, 1999). Empirical research focusing on the application of quality improvement tools and techniques in this area is largely underdeveloped with very little research about the work of the MA and the ILGs in particular. As a result, any research that looks to understand how these tools and techniques and the assumptions underpinning them interact with existing practices provides a new and important contribution to field, both theoretically and methodologically. As Marshak and Grant (2008) suggest, new organisation development (OD) practices like ILGs draw attention to the potential of an organisational discourse perspective where the central focus is language and discursively mediated experience. The nature of the subject matter requires an interpretive approach to understand how ILGs were framed within organizational settings (e.g. Yanow and Schwartz Shea 2006).

Methodology

The concept of an interpretive framework or 'frame' has been used by scholars across a variety of disciplines (see Schön and Rein 1994; Benford and Snow 2000) but most famously explored empirically by Goffman (1974). Goffman defines framing as the 'schemata of interpretation' that enable individuals 'to locate, perceive, identify, and label' occurrences within their life space and the world at large (Goffman 1974: 21). Benford and Snow (2000) suggest that frames perform an interpretive function by simplifying and condensing aspects of the 'world out there', but in ways that are 'intended to mobilize potential adherents and constituents, to garner bystander support, and to demobilize antagonists' (Snow & Benford 1988: 198). Benford and Snow (2000) suggest the result of this activity is 'collective action frames' defined as action-oriented sets of beliefs and meanings that inspire and legitimate the activities of organization. Collective action frames begin by taking as problematic 'meaning work': the struggle over the production of mobilizing and counter mobilizing ideas and meanings. From this perspective, the study of ILGs does not merely view them as carriers of quality improvement ideas and meanings. Rather the actors using them are viewed as signifying agents actively engaged in the production and maintenance of meaning for constituents, antagonists, and bystanders or observers (Snow & Benford 1988).

Our research interest was in identifying a purposive sample of actors (or 'signifying agents') who were centrally involved in framing ILGs. This focused on actors and networks where ILGs were 'active' in the sense that they resonated and were considered part of delivery. It did so by contacting designated service improvement leads within each regional Health Authority in England (Strategic Health Authorities). Prior research identified these as useful and insightful perspectives about the ILGs as these particular organisational roles were established to encourage the quality improvement tools and techniques and draw on material from the Modernisation Agency.

A selection of these improvement leads responded to the research request and agreed to participate in the study. Alongside these regional actors, the research sample then 'snowballed' from regional to local levels by making contact with local managers and facilitators using ILGs. A total of 31 interviews were carried out with actors using ILGs. These were split between 12 regional and 19 local actors. These roles included service improvement managers and leads, workforce developers, specialty (e.g. cardiac) network managers and primary care development managers and leads. A semi structured interview guide was produced that looked to cover a number of areas associated with ILGs. Questions

looked to encourage a conversation about the decision to use the ILGs, how the content and production of ILGs was understood, how they were being used, the experience of using them, and the facilitators and barriers associated with using them. Interviews were all face to face; tape recorded and lasted an average length of 45 minutes.

Data analysis paid attention to what Benford and Snow (2000) describe as the 'core framing tasks' associated with problem identification and action mobilisation related to ILGs. To operationalise this interest it focused on the discursive and narrative processes that were generative of these frames. This analysis of the language and stories associated with ILGs particularly looked at the narratives being formed. These are loosely defined as a sequence of events, experiences, or actions making ILGs into a meaningful whole (Czarniawska 1998; Boje et al 2004). Like others (e.g. Feldman et al 2004) we believed this 'frame articulation' of narrative in connecting and aligning events and experiences was important as its structure reveals what is significant to people about various practices, ideas, places and symbols. Coding this transcribed interview data was both inductive and iterative in focusing on passages of text that illuminated this narrative focusing particularly on decision, use, experience and reflections on facilitators and barriers associated with ILGs (Strauss and Corbin, 1990). Such analysis allowed the theory to emerge from the data through rounds of analysis and interim explanation building, rather than beginning with a pre-existing set of theoretical propositions. Although we were familiar with the literature on quality improvement, the research did not choose a theoretical model a priori but, instead, built one from the data. As with Feldman et al (2004), our insights were grounded in theory without testing any predetermined set of hypotheses about what we would find.

Findings

ILGs were associated with a variety of frames that actors used to organize experience and guide action. Our analysis identified three core framing tasks associated with them. First, they were condensed and situated within a service improvement approach that encouraged quality improvement tools and techniques within healthcare settings. Second, they were mobilized to garner support in the enactment of tools and techniques across different contexts. Third, they were problematised by actors as they reflected on the struggle over the production of mobilizing and counter mobilizing ideas and meanings.

Improvement Leaders' Guides & 'Service Improvement' activity

ILGs were framed by actors as part of the support and development of a 'service improvement' approach across organizational settings. The approach encouraged a system based approach to changing healthcare processes that built on a variety of quality improvement tools and techniques that included process mapping, matching capacity and demand and the use of PDSA cycles. ILGs were used on the basis that they provided an innovative product that 'packaged' improvement tools and techniques in a way that was accessible to all staff. They were an empowering resource to diffuse and get people 'switched on' to using tools and techniques within local contexts.

ILGs formed part of these service improvement efforts in different ways. They were understood as a personal reference or resource for actors when working across different organizational contexts. When 'out in the field', actors described crosschecking against the ILGs to make sure their 'message' was consistent. They provided a reference when putting presentations together and a 'backup' for situations where people posed questions. For example, a cardiac network manager described how they sought to 'mirror' the content of ILGs as they were perceived as containing an authoritative perspective on service improvement tools and methods. The quote below described how a service improvement manager used them as the 'backbone' for working with others:

Because everyone will take their own interpretation of the tools and techniques, I use the guides as a backbone for what I'm telling other people, so they can go away and read them and actually put some into practice... I use them to check I've got the right information, that nothing has been missed or any glaring anomalies were present about a particular training session topic, tool or technique (Service Improvement Manager 3).

ILGs were also used to support the delivery of service improvement training and development programmes. At both regional and local levels ILGs provided 'modules' to structure training and development programmes. An example of this was a local clinical micro systems programme in cardiac services who tailored training around PDSA cycles, the

measurement of improvement, workforce development, capacity and demand, and creativity and innovation.

What's good about them is they fit as a resource for tooling people up and empowering them to work on an issue when they want. We are there to help facilitate and support... but we try and deliver ILGs in a more productive and creative way to complement the training (Cardiac Network Manager 1).

ILGs were also framed as a catalyst for collaborative service improvement efforts. They supported the idea of building capacity and capability in providing people with the ability to spread improvement knowledge and enable individuals and teams to work with tools and techniques at the ground. The quote below from a service improvement director is illustrative of this idea that ILGs could support and enable the collaboration that it was intending to achieve.

One of the things we're trying to do is to give these out to people already out there doing it, where it would be up to them to build capacity and capability as they go back and put this stuff into their organizations... we're trying to spread that existing good practice down to the local level. We want this kind of stuff becoming part of the day job so hopefully one day we will do ourselves out of the job (Service Improvement Director 1)

Improvement Leaders' Guides & the enactment of Service Improvement

ILGs provided an innovative product to support service improvement and spread improvement tools and techniques. That said, what also emerged from actors interpretations of ILGs was an awareness of their limitations as mass media. They believed that prior to the use and application of ILGs, further communication and enactment about the tools and techniques was required to make sense of their content. This is captured in the workforce developer perspective below:

[ILGs] are a tool that allows quick, easily digested information to be imparted to people. However, people will then need support because this is all sounds like a good idea but what does it mean in practice? ... The role of the workforce developer

is to support people in developing ILG skills in the initial stages, by putting it into local context and demonstrating how it could help you solve your problem. We direct them to the ILG specifics but it's up to them to go away and find out if that it works hopefully with the knock on effect of them getting others interested and inspiring them to go onto a project management or leadership course. ILGs would become embedded in their knowledge and enthused to other people about how useful they have been (Workforce Developer 1).

The application of tools and techniques meant bringing them into existence through various interpretive schemes. This was particularly the case for those working at the local level with organizations and teams. Actors referred to changing their communication style to different individuals and personality types in marketing and 'selling' tools and techniques. For example, a practitioner described changing the language of service improvement. She mentioned how when working with clinicians on process mapping the terminology would change to 'understanding things more thoroughly' (Service Improvement Facilitator 2). A different example is presented below from a head of hospital improvement:

Process mapping was about "analysing what's going on, so let's have a look at what's happening on a day to day basis? How is it done? How did that get from there to there?"... Measurement for improvement was sometimes "where are we now", PDSA's would be called something like "running a pilot" (Head of Improvement 1).

Changing the language of improvement tools and techniques also took the form of simplifying or 'demystifying' tools and techniques, as this cardiac network manager illustrates:

It's about people sitting down and saying why we have the problems we have, getting all the right people to say this is what I do and respond "really? I didn't know that" writing it down, agreeing on it and moving forward"... basically what are we going to do is to get you to chat about what you do and write it on a post it note and stick it on a piece of paper. (Cardiac Network Manager 1)

In addition to this change in language, the use of ILGs needed to have local relevance. They required 'live examples', preferably examples participants had been involved in themselves.

They have to be seen as relevant as not just a model in itself but something that makes sense to situations in their own environment... getting people to use them won't work if people can't see what's in it for them (Assistant Director 2)

Translation of tools and techniques into everyday contexts was also helped by the training and development environment in providing the space for learning to occur. Furthermore, identifying opinion leaders with the potential to mobilise other individuals, preferably at board room level, increased the chances of successful adoption.

Improvement Leaders' Guides & critical frames of reference

The sections presented above show how ILGs were used and enacted by actors in their quest to translate a service improvement approach into organizational settings. In the following section we present alternative framings of ILGs that revealed important boundaries and barriers to their application. Whilst actors supported a grass roots approach to diffusing knowledge about tools and techniques, they were aware of limits to their approach. Most notably, some suggested that use of ILGs was limited to those already involved in service improvement and familiar with improvement tools and techniques.

The problem with them is that they are attracting the converted. You know, the enthusiastic ones attending courses or those people already making it happen (Cardiac Network Manager 1).

What reinforced this deficit was the language associated with service improvement. The way in which service improvement was framed was limited to 'pockets of interested people' (Service Improvement Manager 3) and a 'service improvement bubble'.

For someone reading these for the first time you would need a glossary for some of the language... I doubt they were aimed at the ordinary frontline individuals expected to pick these up and use them in a practical way. They are more aimed at us already involved in modernisation (Service Improvement Facilitator 3)

Alongside these language difficulties, actors pointed to the wider implementation issues in relation to ILGs. One notable problem with ILGs was the association with the MA. Rather than associated with bottom up organization development, actors had encountered alternative frames that connected the MA with a top down approach built on performance targets and performance measurement. An example of this was a Service Improvement Lead who described how ILGs were seen as being associated with a 'specialist group' who were 'parachuted into challenged organizations to roll out tool kits around the access agenda'. Service improvement was also associated centralised performance targets.

if it's a government driven target it will probably get done and you'll probably get someone like me coming in to help and support people to get it done (Service Improvement Manager 3).

Also connected to these top down frames of reference was a view of 'service improvement' associated with modernisation in terms of 'getting more for less' and 'efficiency savings' (Service Improvement Lead 1). Such initiatives were not met with a developmental ethos but associated with job cuts and redundancies.

Reflecting on their experiences of delivering tools and techniques, actors described organizational culture issues in relation to organizing around tools and techniques. They were often associated with a 'programmatic' approach to change, with innovations like ILGs seen as 'a project to be completed rather than a state of being' (Cardiac Network Manager 1). Methods such as process mapping and PDSA cycles also proved difficult in contexts not conducive to continuous evaluation and measurement required of these methods.

people to pick out the big numbers in relation to Statistical Process Control, rather than run chart measurements over time (Service Improvement Lead 2)

you try and introduce something and it's often met with "we'll need so many people to do that" or "we need x number of nurses" without thinking about where do you get those nurses from" (Workforce Developer 1)

Alongside these organizational issues, actors highlighted a number of professional issues in relation to the ILGs. Clinical groups in particular were singled out as a problematic group as knowledge and understanding of systems and processes had proven to be a 'blind spot'. Interviewees recalled a number of instances where communicating the service improvement approach was equated with 'management' activity, a distraction from getting on 'with the real business of seeing patients' (Assistant Director 2).

Discussion

The findings presented above show how ILGs were framed in the delivery of service improvement as carriers of ideas about improvement tools and techniques. They also show how the actors using ILGs represented 'signifying agents' who were actively engaged in putting tools and techniques into practice (Snow & Benford 1988).

The implication of these findings suggests that ILGs were supporting leaders and teams to understand 'the basic principles' of improvement. They had the potential to enable, facilitate and support different service improvement learning communities and networks (Bate and Robert, 2002) as part of the 'interpretive support' for tools and techniques (Lave and Wenger, 1991, p. 98). In addition, this evidence draws attention to the limits of 'mass media' and the importance of interpersonal influence and the psychological and social dimensions of change. They attempted to move beyond technical fixes and frame quality improvement as a 'social act' (Batalden et al 2011). The examples related to 'changing the language' were illustrative of the enactment of tools and techniques 'on the ground'. By tailoring different strategies using appropriate styles, imagery and communication channels (Greenhalgh et al, 2004) this enactment was also illustrative of an attempt to distribute leadership around quality improvement tools and techniques (Currie and Lockett 2011). Actors' attempts to mobilise 'followers' to take on and enact leadership roles built on the assumption that if ILGs were combined with their action mobilisation approaches spontaneous collaboration was more likely to occur.

However, the framing of ILGs also reflects the struggle associated with mobilizing ideas and meanings associated with quality improvement. The reference to ILGs operating within a 'service improvement bubble' was illustrated of how tools and techniques were associated with a particular managerial group, something akin to what Ferlie et al (2005) describe as a distinctive 'paradigm' that limited the spread of improvement efforts. The connection made between tools and techniques and 'management' activity was further illustration of the professional boundaries associated with quality improvement tools and techniques (McNulty and Ferlie 2002; Ham et al 2003). As with other research, it seems that clinical and operational staff did not feel as engaged or convinced by improvement methods (Health Foundation 2011).

Organizational boundaries provided further challenges. Enacting tools and techniques as a 'state of being' was in tension with existing assumptions that characterised tools and techniques as 'programmatic' approaches to change limited to short term projects and what Mowes et al (2010) describe as the 'linear cause and effect' approach. Such findings resonate with elsewhere (Health Foundation 2011) that healthcare contexts still lack the appropriate measurement systems for tools and techniques to resonate. These findings show the ongoing challenge to overcome what Batalden and Stoltz (1993) described as the 'traditional' thinking of organisation as a collection of functions rather than process flows, with limited time for critical reflection and learning, and limited emphasis on system improvement at the expense of departmental or professional priorities. As Currie and Lockett (2011) suggest the complexity of professional institutions may render attempts to enact distributed leadership difficult. Within environments framed by 'target-based leadership', products such as ILGs have to coexist with top down performance management and accountability (Currie and Lockett 2011; Currie et al 2009). The ability to 'step up' to leading quality improvement remains an ongoing challenge.

Conclusion

The purpose of this paper is to understand how quality improvement tools and techniques are framed within healthcare settings. It provides an important contribution that furthers our understanding of the social act of improvement. As some of the only empirical material on the NHS Modernisation Agency, it has relevance to all those interested in quality

improvement in the context of UK healthcare. Given the ongoing emphasis on quality improvement in health systems and the persistent challenges involved, it also provides important information for healthcare leaders globally in seeking to develop, implement or modify similar tools and distribute leadership within health and social care settings.

Whilst the possibilities and strengths associated with quality improvement approaches continue to be documented (e.g. Smith 2011; Bate et al 2008), the case of ILGs illuminates the ongoing efforts and difficulties in 'Crossing the Quality Chasm' (Institute of Medicine, 2001) in relation to quality improvement tools and techniques. These findings further support suggestions made elsewhere that the lack of spread and sustainability of quality improvement efforts is rooted in translation problems as models and methodologies developed in different contexts and different knowledge communities struggle to bridge the divide (Waring and Bishop 2010).

In looking to bridge the divide, the case of ILGs reveals that a consideration to framing in relation to language and leadership can help us to reflect the nature and complexity of using quality improvement tools and techniques. Such critical reflection on the principles and rituals guiding action in relation to quality improvement can help leaders in the field begin to explore and understand their influence and reflect on their underlying assumptions of belief, perception and appreciation shaping and possibly limiting quality improvement efforts. This paper suggests that whilst framing was recognised by actors using ILGs, a wider set of strategies are required in order to successfully change existing healthcare practices. As documented elsewhere (Health Foundation 2011), greater engagement of clinicians and understanding what shapes their decision making and actions is required. Furthermore, a greater emphasis is required on applying tools and techniques that take into account a wider set of methods and approaches at all organisational levels. Wider staff engagement and local ownership is crucial to the success of improvement efforts. With the increasing focus on experience-based design and patient engagement in quality improvement (e.g. Bate and Robert 2006), there is also even greater need for future research to incorporate considerations about how patients and their families frame quality improvement tools and techniques and how this may influence the current dynamics of quality improvement.

Limitations

The paper presents an interpretive account of quality improvement tools and techniques. In doing so it aims to contribute new analytical approaches for understanding quality improvement (Shaw, 2010) by attending to the framing of quality improvement. There are however other methodological approaches that could have been utilised, particularly those generating theory based evidence in exploring the hypothesized links between an intervention and defined outcomes in particular contexts (Berwick, 2008; Walshe, 2007; Greenhalgh et al, 2004). Wider outcome assessment, longitudinal studies, and attention to economic and explanatory theories also provide further areas of research in relation to quality improvement in healthcare (Ovretveit and Gustafson, 2002).

The paper captures a particular moment in time. ILGs are still available and housed within the NHS Institute for Innovation and Improvement however an obvious limitation of the paper is that the 'service improvement' agenda has moved on with the NHS Modernisation Agency having long been superseded. Further research is now required to see how more recent quality improvement interventions are being developed. Here the empirical context has been limited to England however further research is also needed in different countries and service contexts.

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Table 1. National Health Service Modernisation Agency Improvement Leaders' Guides

Improvement Leaders' Guide to...	What the guide has to offer?
Process mapping, analysis and redesign	Advice on setting aims and identifying measures to show how changes have made an improvement.
Measurement for Improvement	Advice on how to measure the impact of the changes made and knowing when a change is an improvement.

Matching capacity and demand	Advice on understanding 'bottlenecks' in the system, eliminating queues and waiting lists.
Involving patients and carers	Advice on how to involve patients in improvement programmes and projects.
Managing the human dimensions of change	Advice on how to ensure the best possible outcome when working with different people.
Sustainability and spread	Advice for sustaining and spreading good ideas.
Setting up a collaborative programme	Advice on using a collaborative methodology to innovate and test new models of delivery.
Working in systems	Advice on finding ways to develop long term sustainable improvements.
Building and nurturing an improvement culture	Advice on innovation, learning, team working, communication and trust.
Working with groups	Advice on leading and facilitating an improvement group meeting
Redesigning roles	Advice on creating a motivated and skilled workforce that works together to provide high quality care